Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HEALTHTRUST
P O BOX 890008
HOUSTON TX 77289

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-12-0574-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier claims that the original claim was never received by their claims department. HealthTrust sent in the claims originally via Certified Mail. Texas Mutual did in fact receive the claims because they signed the return receipt. HealthTrust then provided proof of this timely filing and the claim was still denied for timely filing."

Amount in Dispute: $10,920.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute. Texas Mutual has no record of receiving on or about 11/23/10 the billing of codes 997799CP, for dates 11/2/10, 11/3/10, 11/4/10, 11/8/10, 11/9/10, 11/15/10, and 11/16/10. The first date Texas Mutual received the bills was 9/12/11. The bills are untimely."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 2, 2010 To November 16, 2010	CPT Code 97799-CP X 8 Units X 7 DOS	$10,920.00	$5,600.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for Non-Commission Communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. 28 Texas Administrative Code §134.204 sets out medical Fee Guidelines for workers' compensation specific services.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 14, 2011
   - CAC-29 – THE TIME LIMIT FOR FILING HAS EXPIRED.
   - 731 – PER 133.20 PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE THE SERVICE, FOR SERVICES ON OR AFTER 9/1/05.

Issues

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor submit documentation to support the disputed bills were submitted timely in accordance with Texas Labor Code, Section §408.027 and 28 Texas Administrative Code §102.4?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided.
2. Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." Review of the submitted information finds a certified mail return receipt and itemized listing of Article Number 7010 1870 0003 3054 9402 with a sent date of November 19, 2010, and a return receipt signed by Chris Smith, a representative of Texas Mutual Insurance Company on November 23, 2010 in support of its position that the medical bills were originally sent to the carrier. Per 28 Texas Administrative Code §102.4(h), documentation submitted by the requestor in this medical fee dispute sufficiently supports that a medical bill was submitted for payment to the insurance carrier within 95 days after the date on which the health care services were provided to the injured employee.
3. Review of the submitted documentation finds that the requestor in this medical fee dispute has timely filed the medical bills with the insurance carrier in accordance with Texas Labor Code §408.027. This respondent's denial reasons are not supported. The disputed services will therefore be reviewed per the applicable Division rules and fee guidelines. Therefore, reimbursement is recommended per 28 Texas Administrative Code §134.204 as follows:

   Per 28 Texas Administrative Code, Section §134.204(h)(5)(B), a chronic pain management program shall be reimbursed $125.00 per hour for a CARF accredited program. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes. A CARF accredited program is indicated by using the modifier –CA. The requestor did not provide the CARF accredited modifier; therefore, the monetary value of the program will be 80% of the CARF accredited value. Review of the documentation submitted finds that the requestor rendered 8 hours of chronic pain management services on November 2, 2010, November 3, 2010, November 4, 2010, November 8, 2010, November 9, 2010, November 15, 2010 and November 16, 2010 as billed. CPT code 97799-CP will be reimbursed at $100.00 X 8 hrs = $800.00 X 7 DOS = $5,600.00. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $ 5,600.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $5,600.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 3, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.